



SC ADAP INSURANCE APPLICATION

Return To:

Patti Sullivan, STD/HIV
PO Box 101106
Columbia, SC 29211
(803) 898-0214 or (877) 606-8498

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE

Date Rec'd: _____ Status: _____

Status/Date: _____

PATIENT INFORMATION: To be completed by Applicant (Please print)

Name: _____

Last _____ First _____ Full Middle Name _____
Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon ____ Day ____ Year ____ Sex: ____ Weight: ____ Social Security #: ____ / ____ / ____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other _____**SOCIAL AND FINANCIAL DATA**

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated Annual Gross Income
Your Information	Already listed above				

ASSETS (list only if applying for Insurance Continuation):

Cash/Savings \$ _____ Stocks/Bonds \$ _____

Severance Pay \$ _____ Mutual Funds \$ _____

CURRENT MEDICATIONS:_____

Funds for this program come from Federal Ryan White CARE Act, Title II and State programs and are for low-income persons with HIV/AIDS. This program is the payor of last resort. Persons with Medicaid or Veterans Affairs Benefits cannot qualify for this program.

Are you currently approved for Medicaid? ☐ Yes ☐ No **Application pending?** ☐ Yes ☐ No

HEALTH INSURANCE COVERAGE: Attach a copy of the front and back of insurance card. If applying for Insurance Continuation, attach a copy of the insurance/Cobra policy and drug formulary verification. *This application cannot be processed without verification of the drug formulary.*

Applying For: ☐ Insurance Copay
☐ Insurance Continuation**Reimburse Copay To:** ☐ Consortium ☐ Pharmacy
Reimburse Premium To: ☐ Consortium ☐ Patient**If applying for Insurance Continuation (available for individual only):** **Monthly Premium:** \$ _____

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days. By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page.**

Applicant's Signature _____ Date _____

Witness (Signature) _____

Witness (Phone Number) _____

Witness (Print Name) _____

PATIENT NAME: _____ DOB: _____

REFERRAL INFORMATION: To be completed by Physician or Case Manager

I was referred to this program by: ☐ Ryan White Consortium ☐ Health Department ☐ Drug and Alcohol Authority/Commission
Hospital (Please identify) _____ Other (Please identify) _____

CLINICAL INFORMATION: To be completed by Physician

The **lowest pretreatment** CD4 (T4) lymphocyte count was _____ on _____ (date drawn). The **highest viral load** result (if available) was _____ on _____ (date drawn): ☐ pretreatment? ☐ on therapy?

The applicant's current clinical status is: ☐ Asymptomatic ☐ Symptomatic Meets the CDC's case definition of AIDS: ☐ Yes ☐ No

Have you discussed with this patient the importance of adherence with the medications, especially protease inhibitors?

☐ Yes ☐ No

Does this patient have a history of (for counseling purposes only): 1) missed appointments? ☐ Yes ☐ No 2) substance abuse? ☐ Yes ☐ No
3) significant medication non-compliance? ☐ Yes ☐ No 4) mental health issues? ☐ Yes ☐ No

Priority for acceptance is given to persons who are HIV+ with lower CD4 (T4) lymphocyte counts or higher viral loads. Otherwise, please provide: clinical diagnosis, disability status, current symptoms and/or other relevant information for consideration.

Pregnant women with HIV and their neonates receive expedited approval for anti-retrovirals if they meet recommendations of the U.S. Public Health Service and they are not on Medicaid or other payment source. A prisoner on medication will receive expedited approval upon release if we are notified within 30 days of their release. A patient with confirmed acute retroviral illness or seroconversion will also receive expedited approval. If this patient meets these guidelines, please check here and explain: ☐

PLEASE CHECK THE MEDICATIONS YOU ARE PRESCRIBING: Application will be returned as incomplete if no medications are checked.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abacavir (Ziagen) | <input type="checkbox"/> Dapsone | <input type="checkbox"/> Lamivudine (3TC, Epivir) | <input type="checkbox"/> Ritonavir (Norvir) |
| <input type="checkbox"/> Abacavir, Lamivudine, Zidovudine (Trizivir) | <input type="checkbox"/> Delavirdine (Rescriptor) | <input type="checkbox"/> Lamivudine, Zidovudine (Combivir) | <input type="checkbox"/> Saquinavir (Invirase) |
| <input type="checkbox"/> Acyclovir (Zovirax) | <input type="checkbox"/> Didanosine (ddI, Videx) | <input type="checkbox"/> Leucovorin | <input type="checkbox"/> Saquinavir (Fortovase) |
| <input type="checkbox"/> Amitriptyline (Elavil) | <input type="checkbox"/> Efavirenz (Sustiva) | <input type="checkbox"/> Lopinavir/Ritonavir (Kaletra) | <input type="checkbox"/> Sertraline (Zoloft) |
| <input type="checkbox"/> Amprenavir (Agenerase) | <input type="checkbox"/> Emtricitabine (Emtriva) | <input type="checkbox"/> Mirtazapine | <input type="checkbox"/> Stavudine (d4T, Zerit) |
| <input type="checkbox"/> Atazanavir (Reyataz) | <input type="checkbox"/> Enfuvirtide (Fuzeon) | <input type="checkbox"/> Nefazodone (Serzone) | <input type="checkbox"/> Sulfadiazine |
| <input type="checkbox"/> Atovaquone (Mepron) | <input type="checkbox"/> Ethambutol (Myambutol) | <input type="checkbox"/> Nelfinavir (Viracept) | <input type="checkbox"/> Tenofovir (Viread) |
| <input type="checkbox"/> Azithromycin (Zithromax) | <input type="checkbox"/> Famciclovir (Famvir) | <input type="checkbox"/> Nevirapine (Viramune) | <input type="checkbox"/> TMP-SMX DS (Bactrim/Septa) |
| <input type="checkbox"/> Bupropion (Wellbutrin) | <input type="checkbox"/> Fluconazole (Diflucan) | <input type="checkbox"/> Nystatin (Mycostatin) | <input type="checkbox"/> Trazodone (Desyrl) |
| <input type="checkbox"/> Citalopram (Celexa) | <input type="checkbox"/> Fluoxetine (Prozac) | <input type="checkbox"/> Paroxetine (Paxil) | <input type="checkbox"/> Valacyclovir (Valtrex) |
| <input type="checkbox"/> Clarithromycin (Biaxin) | <input type="checkbox"/> Fosamprenavir (Lexiva) | <input type="checkbox"/> Primaquine | <input type="checkbox"/> Valganciclovir (Valcyte) |
| <input type="checkbox"/> Clindamycin (Cleocin) | <input type="checkbox"/> Indinavir (Crixivan) | <input type="checkbox"/> Pyrimethamine (Daraprim) | <input type="checkbox"/> Venlafaxine (Effexor) |
| <input type="checkbox"/> Clotrimazole (Mycelex) | <input type="checkbox"/> Itraconazole (Sporanox) | <input type="checkbox"/> Rifabutin (Mycobutin) | <input type="checkbox"/> Zidovudine (AZT, Retrovir) |
| <input type="checkbox"/> Ketoconazole (Nizoral) | | | |

REFERRING PHYSICIAN:

_____	_____	_____	_____
Name (please print)	Signature	Phone	Date

Address	City	State	Zip Code

State Medical License #	DEA #	Organization/Consortium	

REFERRING CASE MANAGER:

_____	_____	_____	_____
Name (please print)	Signature	Phone	Date

Organization/Address	City	State	Zip Code

CASE MANAGER IF NOT THE REFERRING CASE MANAGER:

_____	_____	_____
Name (please print)	Phone	Date

Organization/Address	City	State
_____	_____	_____
		Zip Code